Register for Kindergarten

IN ADDITION TO THE COMPLETED REGISTRATION FORMS, THE FOLLOWING DOCUMENTS ARE REQUIRED FOR REGISTRATION:

1. **PROOF OF CHILD'S AGE (acceptable documentation includes):**
    a. Original or copy of Birth Certificate
    b. Original or copy of Baptismal certificate (showing date of birth)
    c. Valid Passport
    d. Green Card

2. **IMMUNIZATIONS REQUIRED BY LAW (acceptable documentation includes):**
    a. The child's original immunization record
    b. Immunization record from former school district or medical office

3. **PARENT'S PHOTO IDENTIFICATION (acceptable documentation includes):**
    a. Valid Driver's License
    b. Penn-DOT Identification Card
    c. Valid Passport
    d. Permanent Resident Card (Green Card)

4. **PROOF OF RESIDENCY – TWO REQUIRED (acceptable documentation includes):**
    a. A dated deed, lease, sales agreement, mortgage information
    b. Recent utility bill, credit card bill, property tax bill
    c. Recently dated vehicle registration or vehicle insurance card
    d. If residing with a district property owner/resident, the district property owner/resident must be present, prove their residency as stated above and sign a notarized "Multiple Occupancy Form." **BOTH PARTIES MUST HAVE A VALID DRIVER'S LICENSE OR STATE ISSUED PHOTO ID TO FILL OUT A MULTIPLE OCCUPANCY FORM TO BE NOTARIZED IN OUR OFFICE. MULTIPLE OCCUPANCY FORM CANNOT BE COMPLETED IF EITHER PARTY HAS AN EXPIRED ID.**

5. **PARENT REGISTRATION STATEMENT** (included in packet)

6. **HOME LANGUAGE SURVEY** (included in packet)

Other documents that will be helpful for the success of your child: Report cards/transcripts, all special education information (IEP, ER, RR, NOREP), attendance records and any other records relevant to your child's education.

CONTACT 874-6150 WITH QUESTIONS.

School District of the City of Erie, Pennsylvania

Registration Form – Student Census / Enrollment Information

School: _____ Student ID: _____
Grade: _____ Homeroom: _____

SPECIAL EDUCATION SERVICES INFORMATION

Is your child receiving special education services? ☐ Yes ☐ No If yes, specify: _____
Does your child have an IEP? ☐ Yes ☐ No 504 Plan? ☐ Yes ☐ No GIEP? ☐ Yes ☐ No

STUDENT CENSUS / ENROLLMENT INFORMATION *PLEASE PRINT*

Student's Full Legal Name: _____
Last First Middle
Home Phone:_____ Birthdate:____/____/_____ Gender: M ☐ F ☐ State /
Country of Birth:_____ Date Entered U.S.: _____
Resident Address: _____
Apt. Bldg.:_____ City:_____ State:_____ Zip: _____
☐ Shelter ☐ Motel/Hotel ☐ Relative/Friends ☐ Living in Vehicle

Birth Verification: ☐ Birth Certificate ☐ Other Please Specify: _____

ETHNICITY (RACE) *Must choose one*

☐ American Indian or Alaskan Native *A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition.*

☐ Asian or Pacific Islander *A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian sub-continent, or Pacific Islands. This includes people from China, Japan, Korea, the Philippine Islands, Samoa, India, Vietnam, Guam, Cambodia, Malaysia, Thailand.*

☐ Black (not of Hispanic origin) *A person having origins in any of the black racial groups of Africa (except those of Hispanic origin), Mogadishu, Ethiopian, Sudan*

☐ Hispanic *A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.*

☐ White (not of Hispanic origin) *A person having origins in any of the original people of Europe, North Africa or the Ukraine, Arabic, Iraqi, Bosnia, Lebanese, Russia (except those of Hispanic origin)*

In addition to the box you checked above, if you are multi-racial, please check all that apply:
☐ American Indian ☐ Asian ☐ Black ☐ Hispanic ☐ White
If Pacific Islander, please check this box ☐

PREVIOUS SCHOOL INFORMATION

Has the student ever attended another Erie School District School? ☐ Yes ☐ No
School:_____ Grade:_____ Year:_____
Last school attended Outside the Erie School District
School:_____ Grade:_____ School Year:_____ City:_____ State:_____
List the ***first time*** the student was enrolled
in any school in the US (including preschool and kindergarten) _____
Month Year Grade (Preschool-12)
List the ***most recent*** time the student was enrolled
in any school in the US (NOT including preschool and kindergarten) _____
Month Year Grade (1-12)
List the time the student was enrolled
in **a PA public school** (NOT including preschool and kindergarten) _____
Month Year Grade (1-12)
Is your child presently involved in the Juvenile Justice System? ☐ Yes ☐ No

Parent/Guardian Signature:_____ **Date:** _____

School District of the City of Erie, Pennsylvania

Registration Form – Student Census Information

School: _____

Student Name: _____

Parent/Guardian Email: _____

PARENT/GUARDIAN HOUSEHOLD INFORMATION FOR ADULTS LIVING WITH THE STUDENT

STUDENT LIVES WITH: Please check one box

☐ Parents (both, same household) ☐ Parents (both, separate household)

☐ Father Only ☐ Mother Only ☐ Grandparent(s) ☐ Guardian

☐ Mother/Stepfather ☐ Father/Stepmother ☐ Relatives ☐ Foster ☐ Group Home

☐ Other: _____

If FOSTER, please indicate the district where the child's legal guardian resides: _____

Are there any custody orders regarding this child? ☐ Yes ☐ No If yes, a copy must be provided

---

Parent/Guardian Name: _____ Relationship to Student: _____

Work Telephone: _____ Cell Telephone: _____

Legal Guardian? ☐ Yes ☐ No

Name: _____ Relationship to Student: _____

Work Telephone: _____ Cell Telephone: _____

Legal Guardian? ☐ Yes ☐ No

LIST NAMES OF OTHER CHILDREN LIVING IN THIS HOUSEHOLD

Last Name First	Date of Birth	Last Name First	Date of Birth

HOUSEHOLD INFORMATION FOR PARENTS NOT LIVING WITH THE STUDENT

Parent/Guardian Name: _____ Relationship to Student: _____

Resident Address: _____

Household Telephone: _____ Work Telephone: _____ Cell Telephone: _____

Legal Guardian? ☐ Yes ☐ No

Name: _____ Relationship to Student: _____

Work Telephone: _____ Cell Telephone: _____

Is Either Parent/Guardian Active Military? ☐ Yes ☐ No Name: _____

School District of the City of Erie, Pennsylvania

Registration Form – Student Family Data

School:_____

Student Name: _____

ADDITIONAL EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT/GUARDIAN)

Emergency Contact #1 ☐

Name:_____Relationship to Student: _____

Resident Address: _____

Household Telephone:_____Work Telephone:_____Cell Telephone: _____

Additional Information: _____

Emergency Contact #2 ☐

Name:_____Relationship to Student: _____

Resident Address: _____

Household Telephone:_____Work Telephone:_____Cell Telephone: _____

Additional Information: _____

School District of the City of Erie, Pennsylvania

Registration Form – Student Health Information

Teacher/Homeroom: _____

School: _____ Room #: _____

Student Name: _____ Student ID#: _____

MEDICAL ALERTS (ASTHMA, ALLERGIES, PHYSICAL LIMITATIONS, MEDICATIONS, MEDICAL CONDITIONS, ETC.)

Medical Alert 1: _____

Medical Alert 2: _____

MEDICATION INFORMATION

Is your child taking any medication regularly? ☐ Yes ☐ No

If yes, please list the medication(s): _____

Is your child allergic to any medication(s)? ☐ Yes ☐ No

If yes, please list the medication(s): _____

Indicate allergic reaction: _____

Student Medical Request Release Agreements are available at the school office. This form must be completed for any medication a student will need to take during school hours.

IMMUNIZATION INFORMATION

In order for your child to attend school, immunization documentation needs to be on file at the school by the first day of attendance. If immunization documentation is NOT complete, the student MUST see the school nurse or designee before enrollment can be completed.

INSURANCE

Does your child have health coverage? ☐ Yes ☐ No

☐ Private ☐ Access ☐ Gateway ☐ Med Plus ☐ Ion ☐ Other: _____

If no, healthcare may be available through CARING PROGRAM.

Call toll-free 1-800-986-5437 or 1-800-543-7105

PHYSICAL EXAM

In accordance with PA School Code, a physical examination must be completed on entry into school, and in grades 6 and 11. I wish this examination to be done by the School Physician at no cost to me. ☐ Yes ☐ No

DOCTOR / PRIMARY CARE PROVIDER

Name: _____

Telephone: _____ Extension: _____

Hospital: _____

In an emergency situation, to which hospital do you want your child sent? Indicate on the line above.

If a parent or legal guardian cannot be notified and immediate medical care is indicated, the school will call 911. However, the Erie School District will in no case accept financial responsibility for care.

Parent/Guardian Signature: _____ **Date:** _____

This form will be given to the nurse after registration.

School District of the City of Erie, Pennsylvania

Registration Form – Student Health Information

Teacher/Homeroom:_____

School:_____ Room #: _____

Student Name:_____ Student ID#: _____

Health Concerns ***Parents/Guardians are responsible for providing full details on any medical conditions to the school nurse.***

Does your child have a health problem?

Check and explain where appropriate		**Medication(s)**	**Medication Given At Home** YES	NO	**Medication Given At School** YES	NO
☐ Allergies						
☐ Asthma						
☐ Attention Deficit Disorder						
☐ Bowel/Bladder						
☐ Diabetes						
☐ Emotional/Behavioral						
☐ Fractures						
☐ Head Injury						
☐ Hearing						
☐ Headaches						
☐ Heart						
☐ Hyperactivity						
☐ Seizures or Fainting						
☐ Skin Conditions						
☐ Speech						
☐ Surgeries/Hospitalizations						
☐ Tuberculosis						
☐ Varicella (Chickenpox)						
☐ Vision						
☐ Other						

☐ Student has **NO** health concerns

Please check all that apply:

☐ Glasses ☐ Contacts ☐ Hearing Aids

☐ Prosthesis or Physical Aids (please list): _____

☐ Other: _____

Information obtained on the Health History is solely used by the school nurse to ensure that sound decisions are made to meet the health needs of your student. Health information will only be shared with school staff on a "need to know basis" and parents/guardians will be included in this process. Health information will not be shared with any other outside health providers without the expressed written permission of the parent/guardian. If you have any questions or concerns please contact your student's school nurse.

Parent/Guardian Signature:_____ **Date:** _____

This form will be given to the Nurse after registration

pennsylvania
DEPARTMENT OF EDUCATION

HOME LANGUAGE SURVEY

ALL newly registering students regardless of race, nationality, or language origin MUST complete this form. Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

Student Information (Parents/Guardians should complete this section):

Child's first name: _____

Child's family name: _____

Child's Date of Birth: _____
(Month/Day/Year)

Questions for Parents or Guardians

1. Is a language other than English spoken in the child's home? ☐ No ☐ Yes (language) _____

2. Does your child communicate in a language other than English? ☐ No ☐ Yes (language) _____

3. What is the language that your child first learned to speak? _____

Parent/Guardian Signature: _____ Date: _____

Interpreter Provided ☐ No ☐ Yes

IMMUNIZATION REQUIREMENTS

The Pennsylvania Department of Health requires the following immunizations as a condition of attendance for all children entering school.

Diphtheria	4 doses – one dose after age 4
Tetanus	4 doses – one dose after age 4
Polio	3 doses – one dose after age 4
Hepatitis	3 doses – doses correctly spaced
Measles, Mumps, Rubella (MMR)	2 doses
Varicella (Chicken Pox)	2 doses given after age 1 **OR** mo./yr. of chicken pox signed by parent or doctor

Exceptions:

Medical	A medical contraindication because of rare conditions. Requires a statement from a physician or clinic
Religious	Which requires a statement from parents/guardians

PHYSICAL AND DENTAL EXAMS

A physical exam is required before entering kindergarten to make sure your child is healthy and ready for school. Take the enclosed form to your physician/clinic and have the doctor complete it. The form can then be mailed to school or returned to the school on the first day of school. Physical exams completed from last September to the present are acceptable. Your child will be scheduled for this exam at school if we do not receive a report.

A dental exam is required before entering kindergarten to make sure your child is healthy and read for school. Take the enclosed form to your dentist/clinic and have the dentist complete it. The form can then be mailed to school or returned to the school on the first day of school. Dental exams completed from 9/1/13 to the present are acceptable. Your child will be scheduled for this exam at school if we do not receive a report.

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL_____ DATE_____ 20 ___

NAME OF CHILD			AGE	SEX		GRADE	SECTION/ROOM
Last	First	Middle		☐ M	☐ F		

ADDRESS

No. and Street	City or Post Office	Borough/Township	County	State	Zip

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT								LEFT								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date _____

Date of birth _____ Age at time of exam _____ Gender: D Male D Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? D No D Yes (If yes, list specific allergy and reaction.)

D Medicines D Pollens D Food D Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: *Has the student…*	YES	NO
1. Any ongoing medical conditions? If so, please identify: D Asthma D Anemia D Diabetes D Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: *Has the student…*	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: *Has the student...*	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: D Heart murmur or heart infection D High blood pressure D Kawasaki disease D High cholesterol D Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: *Has the student...*	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: *Has the student…*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: *Has the student…*	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? D Yes D No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: D less than 1 year D 1-2 years D greater than 2 years		
SOCIAL/LEARNING: *Has the student…*	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: D Anemia/blood disorders D Asthma/lung problems D Behavioral health issue D Diabetes D Inherited disease/syndrome D Kidney problems D Seizure disorder D Sickle cell trait or disease Other		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: D Brugada syndrome D Cardiomyopathy D High blood pressure D High cholesterol D QT syndrome D Marfan syndrome D Ventricular tachycardia D Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes D **No** D

Physical exam for grade: K/1 D **6** D **11** D **Other** D	**CHECK ONE**			***ABNORMAL FINDINGS / RECOMMENDATIONS /REFERRALS**
	NORMAL	***ABNORMAL**	**DEFER**	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected D				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes D **No** D

Physical exam performed at: Personal Health Care Provider's Office D **School** D **Date of exam_____20_____**

Print name of examiner _____

Print examiner's office address_____ **Phone**_____

Signature of examiner_____ **MD** D **DO** D **PAC** D **CRNP** D

STUDENT NAME:

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason:_____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason:_____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason:_____ Date Rescinded:_____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)
STUDENT NAME: